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Knowledge, Skill, and Attitude Towards Workplace Violence Interventions Among Emergency Department Nurses

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KNOWLEDGE, SKILL, AND ATTITUDE TOWARDS WORKPLACE VIOLENCE INTERVENTIONS AMONG EMERGENCY DEPARTMENT NURSES

by

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Abstract

According to the National Institute for Occupational Safety and Health (2014), the United States Bureau of Labor Statistics (UBLS) reported health care industry workers more likely to experience workplace violence (WPV) than all other private industries, emergency department workers particularly. The trend in WPV toward ED nurses is rising despite efforts to intervene and prevent these occurrences. Research has shown that WPV training and education programs, reporting systems, policies, and managerial support have been shown to be helpful in reducing its occurrence. This study investigates the knowledge, skills, and attitudes towards workplace violence interventions among emergency department nurses. The objective is to identify barriers to reducing its occurrence.

Based on current literature, an amended version of the Emergency Nurses Association (ENA) Workplace Violence Surveillance Study survey tool (2011) was distributed to all eligible members of the Rhode Island State Council of the ENA. The amended version of the ENA workplace violence survey composed of 31 multiple choice questions. The questions on the survey were categorized into describing either knowledge, skill, or attitude (beliefs) in order to measure the sought-out objectives. Analysis of the results from the survey indicate knowledge based and attitude (belief's) based barriers proved to be the most significant finding reported by ED nurses related to to the continuing rise in WPV and use of existing WPV interventions. Recommendations should be targeted to improve education on certain procedures regarding WPV interventions, integrating follow-up/debriefing after a violent event occurs and including ED nurses in the post WPV policy and procedure analysis.

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Background

According to the American Journal of Managed Care (Stephens, 2019), the occupational safety and health administration (OSHA) reports that healthcare employees is more common than people understand and that the health care setting accounts for nearly 75% of workplace assaults (OSHA, 2016). Furthermore, the emergency department (ED) is identified by the World Health Organization (WHO) as a particularly vulnerable area to experience WPV given its frequent exposure to patients and/or visitors with psychiatric disorders, substance abuse disorders, victims or perpetrators of violence, and delirium from various causes (WHO, 2002). Workplace violence is defined by the National Institute for Occupational Safety and Health (NIOSH) as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty" (NIOSH, 2019). In addition, The Emergency Nurse's Association (ENA) defines WPV as "an act of aggression directed towards persons at work or on duty and ranged from offensive or threatening language to homicide" (ENA, 2011b, p 9)

The trend in WPV toward ED nurses is rising despite efforts to educate, train, and prevent these episodes from occurring (ENA, 2011a). The culture of violence and acceptance of violence in the workplace setting, particularly among ED nurses, is one that needs a further, and a more problem focused opposition (Park, Cho, Hong, 2015). Currently, based on recommendations from various national and statewide associations and agencies including NIOSH (2019), Occupational Safety and Health Administration (2016), The Joint Commission (2019), ENA (2011b), American Nurses Association

(ANA, 2015), interventions to prevent WPV are made available to nurses. Recommendations such as training and education programs, reporting systems, WPV response policies, zero tolerance of WPV policies, and organizational support policies have been developed and implemented to assist in eradicating the incidence of WPV. Despite these seemingly available interventions, nurses and other healthcare workers are still the highest group within the workforce to fall victim to WPV (OSHA, 2016). Currently, there is no 'best practice' or 'standard of practice' directly related to WPV in the ED (ENA, 2011a). The ENA also states that "emergency nurses, with their high risk for experiencing WPV, can serve an integral role in all aspects of violence prevention, planning, monitoring, and reporting" (ENA position statement, 2019, p 3). Recommendations from various reputable organizations on WPV and interventions are in place to protect HCP, however, if workers and health care organizations neglect to implement these interventions to their fullest, WPV will continue to prevail and be an 'accepted' part of the job.

Identifying the knowledge, skill, and attitudes towards workplace violence interventions among ED nurses will provide organizations with objective data regarding the barriers to current WPV interventions. Knowledge is recognized as facts, information, and skill acquired by a person through experience or education- a theoretical or practical understanding of a subject. Skill is recognized as the ability to do something well. Attitude is recognized as a settled way of thinking or feeling about something- typically one that is reflected in behavior. By exploring these three factors related to WPV interventions, areas for improvement of current WPV interventions and training may be identified.

The purpose of this major project was to assess the knowledge, skills, and attitudes towards workplace violence interventions among emergency department nurses.

Literature Review

Databases CINAHL, Medline, PubMed, Ovid, and Whiley were utilized to explore publications pertaining to this literature review. Keywords used in the search included 'workplace violence', 'healthcare workers', 'nursing', 'emergency department', 'patient volume', 'practice change', 'interventions', 'recommendations', 'assessment tool', 'perceptions', 'education', 'barriers'. The articles included in this review were published between 2002 to 2019. Publication types include research studies, editorials, position statements, and review articles.

Emergency Care Setting

The American college of Emergency Physicians (ACEP) defines emergency care as a medical specialty dedicated to the diagnosis and treatment of unforeseen illness or injury. It includes the initial evaluation, diagnosis, treatment, coordination of care among multiple providers, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care (ACEP, 2015). Emergent visits for myocardial infarction, stroke, trauma, sepsis, and acute respiratory distress are a few examples of conditions that are most commonly seen and treated in emergency departments across America (Vashi et al, 2019). Expedited care for such conditions significantly effects patient's expected outcomes related to morbidity and mortality. Delays in emergency care due to ED overcrowding is thus correlated with poor outcomes, adverse events, and an increase in mortality rates (Vashi et al, 2019).

Increasing emergency department (ED) patient volume is an international epidemic that has been on the rise over the last decade (DiSomma et al, 2015). The cause of ED overcrowding is multifactorial and has led to numerous adverse and consequential

adverse effects to not only patients but to healthcare providers as well. DiSomma (2015) identified several internal and external factors that contribute to ED overcrowding. Internal factors highly correlated to ED overcrowding include nursing shortage, physician shortage, limited number of in-patient and ED hospital beds, and closing of other near-by emergency departments. External factors identified by DiSomma (2015) and other studies report that older patients living longer, the opioid epidemic, lack of health insurance among patients, lack of primary care physicians (PCP's) and patient with PCP's, and access to pre-hospital care services all contribute to ED overcrowding (Ukkonen et al, 2019; Lovegrove et al, 2019).

Emergency departments across the United States have sustained a nearly thirty million patient per year increase (Hoot & Aronsky, 2008). Overcrowding in the ED inevitably has a snowball effect on patient care leading to long wait times, lack of privacy, decreased patient satisfaction, and untimely treatment for acutely ill patients. Inevitably, consequences of overcrowding result in increased adverse events, increased patient mortality, and increased length of stay (DiSomma, 2015). Additionally, in the United States, the unique health care system requiring all ED's to treat patients despite ability to pay has led to ED's becoming a 'safety net' for those who cannot afford health insurance and are in need of provider care. Hospitals and EDs across the US are closing because of financial burdens which in turn leads to other near-by hospitals taking on the increased patient volume of closing health care facilities which then contributes to ED overcrowding (DiSomma, 2015).

Factors contributing to Workplace violence

Chen, Ku, & Yang (2013) identified factors that contribute to the prevalence of WPV in the emergency department. ED waiting room overcrowding, long wait times to see a provider, lack of privacy, and patient perception of being 'low-priority' in emergency care are closely correlated with the prevalence and likelihood of workplace violence. The external factors identified by this study report that ED overcrowding results in projected anger and frustration toward ED staff. Phillips (2016) reported that risk factors for physically violent behavior need to be identified and WPV prevention training should include education on how to identify escalating behavior. Projected anger has been identified as a precursor to verbal assault, and likewise verbal assault has been identified as a risk factor for battery (Lanza, Ziess, & Rierdan, 2006). Emergency departments are individually unique and without concrete legislation to abide by, healthcare organizations are not required to have specific workplace violence prevention strategies in place (Phillips, 2016). Phillips (2016) proposes that the solution to mitigating WPV in the healthcare setting is multifactorial and requires the attention of more than just the health care organization. Policy and law makers, law enforcement, the individual worker, and healthcare organizations need to come together in a collaborative approach, remain consistent, and stay committed to finding a more effective solution to promoting a safer work environment for HCP's (Phillips, 2016).

Defining Workplace Violence

The National Institute of Occupational Safety and Health (NIOSH) recognizes that the United States employs more people in areas of the healthcare setting than in any other sector of the workforce (NIOSH, 2002). Furthermore, OSHA recognizes that recent

data indicates that hospital workers are at high risk for experiencing violence in the workplace and at a much higher rate than all other private-sector industries (OSHA, 2016). Within the NIOSH *Occupational Hazards in Hospitals* publication (2002), the authors define specific types of violence and provide examples of types of verbal and physical violence that fall under their definition of WPV. Verbal threats can include "expression of intent to cause harm, verbal threats, threatening body language, and written threats". Physical assaults include "attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives", furthermore they include a definition for muggings "aggravated assaults that are usually conducted by surprise with intent to rob/steal" (NIOSH, 2014). NIOSH outlines who is at greatest risk and where violence may occur. Although hospital workers in general are at higher risk for WPV, nurses and nurses' aides are at the highest risk for WPV due to high volumes of direct contact with patients and visitors. While violence can occur anywhere in the workplace and towards any member of the hospital staff, violence is most frequently seen in psychiatric facilities, emergency rooms, waiting rooms, and geriatric units (NIOSH, 2014).

In the same year, NIOSH released the WPV workbook titled *VIOLENCE, Occupational Hazards in Hospitals* (2002), and The World Health Organization (WHO) released the *Framework Guidelines for Addressing Workplace Violence in the Health Sector (2002)*. In a common report with NIOSH, the WHO recognized that "while workplace violence affects practically all sectors and all categories of workers, the health sector is at major risk. Violence in this sector may constitute almost a quarter of all violence at work" (WHO, 2002, p 1). It also estimated that WPV may effect nearly half

of healthcare workers in some manner. This climbing trend of WPV in the health sector does not only effect the worker, it has the potential to have significant impact on the delivery of healthcare, a decrease in the quality of care provided, decrease job satisfaction, and could cause the worker to even leave the health care profession entirely. With this potential downstream effect of WPV and its negative consequences, the healthcare industry may eventually see "a reduction in timely emergency care services available to the general population and increase cost of healthcare" (WHO, 2002, p 1).

The World Health Organization (2002) defines WPV as "incidence where staff is abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being, or health" (WHO, 2002, p 3). A part of WHO guidelines that differ from other definitions and inclusions as to what is considered psychological violence. The guidelines state that while verbal and physical abuse have always been recognized, psychological violence has been underestimated and deserves more attention. Guidelines go on to state that while psychological violence often doesn't cause major health problems in a single and isolated event, repeated psychological violence can have a snowball effect on a person and become a significant form of violence with long term effect. Psychological violence is defined as "intentional use of power, including threat of physical force, against another person or group that can result in harm to physical, mental, spiritual, moral, or social development" (WHO, 2002, p 4). Included in its guideline are the definitions of specific forms of physical and verbal violence that defines assault, attack, abuse, bullying, mobbing, harassment, sexual harassment, racial harassment, threat, victim, perpetrator, and workplace.

The meaning, risk for, and the need for interventions and protection from workplace violence differs among occupational settings. Even in the setting of healthcare, various reputable organizations have their own definitions of WPV, and terms related to WPV (Boyle & Wallis, 2016). The Emergency Nurses Association (ENA) is a nationally known association of nurses that is dedicated to excellence in the present and future of emergency nursing. From 2009 to 2011, the ENA conducted the Emergency Department Surveillance Study in which they released a position statement towards violence in the emergency care setting to address the cause, effect, and needs of emergency departments on a national scale. Within this survey, the ENA released its own definition of workplace violence stating it is "an act of aggression directed towards persons at work or on duty and ranges from offensive or threatening language to homicide" (ENA WPV toolkit, 2011, p 9). In response to the survey, the ENA released a toolkit that outlines its own position and comprehension of the full magnitude of the problem which will be discussed later in this literature review.

In attempts to define different types of workplace violence, Boyle & Wallis, 2016 defined six central actions of workplace violence for use in health sector research. The authors state that while patient safety research networks have their well-established definitions of patient safety, there was "no consensus document that exists that outlines definitions and concepts that pertain to the workplace violence research environment in the health sector" (p.1). The authors state that as a result of vague and interchangeable definitions of WPV in the health sector, the research environment of WPV is ambiguous and unclear.

A two-part study by Boyle & Wallis (2016) included part one, a literature review, and part two, a group discussion that was held during the Fourth International Violence in the Health Sector Conference in 2014 to discuss and compile definitions for specific workplace violence acts. The literature review was a compilation of articles obtained from medical related electronic data bases through June of 2014. All categories of publications were accepted into the collection of literature which lead to a total 91,681articles; only 82 of the total number of articles were included based on inclusion criteria. Thirty-nine of the original 82 with excluded leaving just 43 of those articles for review. Articles were excluded because they did not report definitions relating to workplace violence.

The second part of the study (Boyle & Wallis, 2016) included a workshop discussion and debate at the conference following the literature review. Eleven participants were included in the development of the definitions of WPV. Participants came from a variety of care settings and even included members from the correctional system. To ensure consistency of what constitutes a 'definition', Agervold's (2007) definition was used in the development of each phrase or word. Using standards of a definition, the participants came up with the definition of 6 central actions of workplace violence for use in the health sector:

(a) Bullying- Is a person's perception of repeated negative actions such as harassment, intimidation, exclusion, isolation, hostility, character assignation and constant criticism

(b) Verbal Abuse- Is a person's perception of being professionally and personally attacked, devalued, or humiliated via the spoken word

(c) Threat- Is a person's perceptions of an intention to inflict personal pain, harm, damage, disadvantage, or phycological harm.

(d) Physical Abuse- Is a person's perception of an unwelcome or uninvited action that involves physical contact with a person with the intent of causing psychological, emotional, and bodily harm.

(e) Sexual Harassment- Is a person's perception of sexual propositioning or unwelcome sexual attention.

(f) Sexual Abuse- Is a person's perception of an unwelcome or unwanted action that involves physical contact of a sexual nature (Boyle &Wallis, 2016).

The authors respect and give attention to the previously defined words from other work sectors such as legal, business, and scientific occupations (Boyle &Wallis, 2016) when defining workplace violence. The authors claim, that although there are many accepted variations of what is considered workplace violence, for the first time in health sector research, a general consensus was agreed upon and developed by healthcare professionals to accurately define workplace violence within the health sector. Designating these six definitions to workplace violence specifically in the healthcare sector may lead to more consistency in further investigations and gain more accurate insight into the phenomena of workplace violence.

Workplace Violence in Nursing

In light of the recent, increasing trend of workplace violence towards healthcare workers, Phillips (2016) constructed a review article to highlight the current knowledge about WPV in the healthcare setting. The review article was released after a surgeon at Brigham and Women's Hospital in Boston, Massachusetts was shot and killed at work by

the son of a deceased family member in January of 2015. While this event got heavy media coverage due to its violent nature, the author goes on to expose the full magnitude of WPV in healthcare setting beyond just physical harm. They recognizes that WPV in the healthcare setting for the majority is verbal assault and others acts that "constitute assault, battery, domestic violence, stalking, or sexual harassment" (Phillips, 2016, p 1661). Despite the fact that healthcare WPV is a vastly underreported, persistent, and a still tolerated daily occurrence, research to date is mainly directed at quantifying the problem rather than identifying a solution to mitigate risks of WPV (Phillips, 2016). Phillips (2016) recognizes the magnitude of the problem, and that no WPV interventions have produced a significant effect in preventing violence to date.

According to this review (Phillips, 2016), assault rates are directly correlated with the amount of direct patient care a healthcare provider has with patients. Nurses naturally make up a significant percentage of those who fall victim to WPV. Emergency department and psychiatric nurses in particular have the highest rates of WPV, however, WPV reaches all units within hospitals (Phillips, 2016). Well-deserved attention on the less common areas of WPV is necessary to understanding the magnitude of WPV towards nurses as a whole. Using statistical data from the various large studies, the author revealed that the annual incidence of verbal and physical assaults was 39% and 13%, respectively. In another large study, 46% of nurses reported some type of workplace violence during their five most recent shifts, of these, one third were physically assaulted (Duncan, Estabrooks, Reimer, 2000).

Chen, Ku, and Yang (2013) conducted a quantitative descriptive research study that aimed to evaluate the prevalence and sources of verbal and behavioral violence

experienced by nursing staff in different departments over the course of one year. They sought to determine common factors from nurses who had experienced WPV. This descriptive, correlational study used a structured questionnaire to collect information about workplace violence experienced by nurses within one year of working. The study was conducted in a public hospital in Taiwan with a sample of 880 nurses which had an excellent response rate of 90%. The hospital was a 1266-bed general public hospital. The questionnaire was separated into two parts including demographic characteristics and the WPV training experience of the nurses, and several closed ended questions on WPV types, sources, whether reports included violence encountered, if not, the reason. The questionnaire was adopted from the *International Labour Office/ International Council of Nurses/ World Health Organization,* WPV in the Health-Sector-Country Case Studies, research instrument in which adjustments were made for relativity. The instrument was validated using six experts in the field of WPV and research for the appropriateness of wording in the questionnaire. The expert content validity index was 0.83-0.93. The questionnaire was piloted using a group of 30 participants; consistency of content within the survey was deemed to have a reliable correlation by observing responses in a pre-test/post-test spaced 10-14 days apart resulting in a reliability correlation coefficient of 0.98 which suggests good reliability. The data was collected over a two-month period and survey responses were based off recall of events from the past year for each survey participant.

The results significant for observing WPV among nurses included place of occupation and previous WPV training received. Close to 70% of nurses who participated worked directly in hospital wards, and only 6% of those nurses reported having received

WPV training. Almost 82% of the nurses who participated experienced some form of WPV within the given year. The most common form of violence experienced was verbal assault with 50% of nurses reported having experienced verbal assault, 30.6% of nurses experienced verbal and behavioral violence (threatening behavior and physical attack) and 1.7% from physical violence. Responses were analyzed using a chi-square test to examine the relationship between certain demographic data and WPV experienced. Results suggested that those working in emergency departments were most likely to suffer from WPV ($p = 0.035$). Another significant finding was a direct correlation between WPV experienced and WPV training; those who had not received formal WPV training tended to have more incidence with WPV ($p = 0.038$). Logistic regression analysis was used to determine which areas saw the highest incidence of WPV and results suggested that out-patient nursing areas and emergency departments experienced WPV 2.25 ($p = 0.009$) times more often that operating rooms and intensive care units. Sources of workplace violence was from patients (61.4%), patients-family members and friends (60.8%) during times of physical and mental distress and pressure. The most common areas where WPV is experienced are those who have the highest burden of mental and physical stress. Chen, Ku, and Yang (2013) concluded that a key factor in determining risk for WPV was place of occupation. Emergency rooms were found to have the highest incidence of violence and may be attributed to long wait times and the patient/family perception of not being considered a 'priority'. External factors such as longer wait times and priority perception in turn lead to misunderstandings, projected anger and violence towards nursing staff from patients and family members (Chen, Ku, & Yang, 2013).

Author recommendations from this study state that healthcare systems as a whole in conjunction healthcare officials need to reevaluate the current 'antiviolence policies' and take more promising action to prevent WPV against nurses (Chen, Ku, & Yang, 2013). This suggests that a commitment from administrative and healthcare officials in support of nurse safety is paramount in reduction of WPV in the healthcare setting. Interventions should, according to the authors, focus on administrative efforts to recognize and develop strategies regarding the reduction of workplace violence by implementing WPV policies, reducing wait times, changing treatment options for the elderly, and providing de-escalation training in order to properly handle WPV(Chen, Ku, Yang, 2013).

Workplace Violence and Emergency Department Nurses

Organizations such as the NIOSH (2014) and the World Health Organization (2002) report WPV towards nurses is most prevalent in emergency departments (ED's). According to data collected by NIOSH from The Bureau and Labor Statistics, WPV may occur anywhere is the hospital, but is most frequent in psychiatric wards, emergency departments, waiting rooms, and geriatric units (NIOSH, 2014). The *Framework Guidelines for Addressing Workplace Violence in the Health Sector* (WHO, 2002) states that certain areas have extremely high risk for WPV. These specific locations and situations include working with the public, working with people in distress, areas more 'open' to violence such as emergency departments, and working with objects that have street value such as medicine, syringes, money, and objects that are in '*close reach*', put workers at higher risk for violence (WHO, 2002). The previously stated circumstances

that are considered high risk according to WHO, are often present within an emergency department setting, making ED nurses especially vulnerable to WPV.

According to a study from 2009 regarding violence against nurses working in emergency departments, public access to ED's, lack of trained hospital personnel, and the high stress work environment all make staff vulnerable to violence (Gacki-Smith, J. et al, 2009). Furthermore, background provided for this study suggests that EDs often encounter people that are in pain, distress, and have a degree of anxiety which creates distress for other waiting patients and family members. Additionally, patient distress is often accompanied by family members and visitors who are equally frustrated with long wait times, the perception of low priority, cramped spacing in waiting rooms and lack of privacy. Together these daily occurrences often foreshadow the escalation that sometimes results in the act of verbal and/or physical violence towards ED nurses (Gacki-Smith, J. et al, 2009).

ED nurses also have the responsibility for caring of those in acute psychiatric emergencies, under the influence of a substance who can often be disruptive and have significantly impaired judgement. Unfortunately, patients who create a disruptive, high tension work environment are often those who commit an act of assault whether it be verbal or physical which leads to a hostile work environment for not only ED nurses, but for the other patients that also require medical treatment. Statistical data from this article observed by The Bureau and Labor Statistics (2004) reports that 46% of nonfatal assaults and violent acts against healthcare workers that involved days off work were committed against RN's. An additional study reports the prevalence of violence against ED nurses finding 82% of ED nurses were physically assaulted at work within the previous year

(May & Grubbs, 2002). Another study reported that the incidence of verbal abuse is increasing with reports of such abuse to be 87.2% emergency departments (Chen, Ku, Yang, 2013).

Types of Workplace Violence in the Emergency Departments

In a quantitative descriptive study addressing risks of violence against healthcare staff in emergency departments, the prevalence of patient and visitor violence in eight emergency departments in northeastern Italy was explored (Berlanda et al, 2019). The data for this study was collected via an online questionnaire consisting of 69 questions. Questionnaires were distributed and completed in February of 2019, and included measures of patient and visitor violence, attachment style, and job satisfaction. This study adopted the definition of violence from the European Commission which states "all situations when a worker is offended, threated, or attacked in conditions directly related to his/her job and when these situations directly or indirectly endanger his/her safety or involve an explicit or implicit challenge to his/her well-being or health" (International Labor Office, International Council of Nurses, World Health Organization, & Public Services International, 2002)

Of the 395 nurses and doctors that received the email, a total of 149 questionnaires were completed resulting in a response rate of 37.7%. Of the completed questionnaires, 58.4% of respondents were physicians and 41.6% were nurses. For each variable, a composite score was given by averaging respective items and using pearson correlation to establish associations between variables. A paired sample *t*-test analyzed the differences between emotional and physical violence, emotional violence perpetrated

by patient, and emotional violence perpetrated by visitors, physical violence perpetrated by patients, physical violence perpetrated by visitor, and inappropriate touching by patients and inappropriate touching by visitors.

Three different types of violence were evaluated to include emotional, physical, and sexual violence. Emotional violence included verbal abuse, intimidation, obscene behavior, threatening behavior, threats, threats made over the telephone, threats to family, slander, and vexatious complaints. Physical violence included property damage or theft, physical abuse, injury, and stalking. Sexual violence included inappropriate touching, sexual harassment, and sexual abuse. The results revealed there were differences in the type and frequency of violence experienced by healthcare staff and those who the violence was perpetrated by; patient or visitor. The most common form of violence experienced by ED nurses was in a form of emotional abuse. Violence was found to be perpetrated more often by patients than visitors of patients and inappropriate touching was more commonly perpetrated by patients more than visitors. In a comparison of physician experienced violence to nurse experienced violence, nurses reported a higher experience of violence on multiple variations of what is considered violence. ED nurses reported higher rates of patient-perpetrated emotional violence 60% ($p< 0.001$), visitor-perpetrated emotional violence 57% ($p< 0.001$), patient and visitor-perpetrated emotional violence 55% ($p< 0.001$), patient-perpetrated physical violence 39% ($p< 0.020$), patient and visitor-perpetrated physical violence 27% ($p<0.025$), inappropriate touching by patients 76% ($p<0.020$,) and inappropriate touching by visitors 51% ($p<0.015$).

The results of this study support existing evidence that WPV in the health sector, particularly in emergency departments is extremely prevalent and poses a significant risk

to emergency department nurses and other healthcare staff as well. Berlanda et al, (2019) suggests the healthcare workers should be trained to recognize and prevent violence and/or manage violent situations adequately. Training should also include the identification of appropriate and constructive coping mechanisms after having dealt with a violent situation. A 'safe practice' environment is also suggested to promote a work environment that fosters patient, visitor, and staff safety such as putting limitations on ligature risks, zero-tolerance policies, adequate staffing, security presence, emergency alarms, and organization protocols for managing violent situations. Lastly, the authors call for more occupational health legislation to be implemented in order to foster an environment of teamwork between hospital systems, the correctional institution, and health legislators to hold workplace violence perpetrators and hospital systems accountable for addressing workplace violence (Berlanda et al, 2019).

Accreditation and Workplace Violence

The Joint Commission (TJC) is a national organization that is responsible for accreditation and certification of thousands of hospitals across the Unites States. Being accredited and certified from TJC recognizes that a hospital meets certain quality markers regarding patient and hospital safety standards. This includes quality markers regarding WPV prevention. TJC (2012) provides resources for organizations to utilize for WPV interventions based on what has worked well in other institutions, as well as recommendations from occupational safety organizations OSHA and NIOSH, with the objective for improving WPV prevention. For the purpose of this project, the researcher will focus on the 'behavioral' and 'administrative' recommendations for workplace violence interventions. WPV recommendations include action from leadership support of

a ‘zero harm’ work environment, taking responsibility for identifying, addressing, and reducing WPV, emphasizing importance of reporting WPV. Specifically stated within this sentinel event is that the strategies put in place by leadership to reduce WPV is to the responsibility of leadership solely, and that the burden of WPV must not be placed upon the victims of WPV (TJC Sentinel Event Alert, 2018). Additionally, TJC recommends leadership should encourage conversations about WPV openly, develop systems and tools to help nurses identify potential violent occurrences, develop protocols with guidance and training as required by OSHA, and provide adequate follow up, support, counseling, and deposition of each violent occurrence regardless of its nature (TJC, 2012). The above stated recommendations, and many more that are outlined in publications from TJC are standards that are required by all hospitals. Hospital organizations risk losing TJC accreditation if they fail to operate and uphold their system to these safety standards.

Workplace Violence Interventions in Healthcare

In response to the growing evidence of the prevalence of WPV in healthcare, out-of-hospital interventions are being called upon to improve prevention strategies. Philips (2016) states the development of an appropriate program to prevent workplace violence requires the consideration of issues involving individual workers, law enforcement officials, and health care organizations to determine their unique vulnerabilities and solutions. Healthcare organizations that enforce interventions and take action when violence is committed is necessary to ‘see this problem through to a common solution for the greater good and protection of nurses in the work setting’ (Phillips, 2016). The ‘broken windows’ principal (Kelling & Wilson, 1982), a criminal-justice theory that

states apathy toward low level crimes creates a neighborhood conducive to more serious crime, also applies to WPV in the healthcare setting (Hesketh, Duncan, and Estabrooks et al, 2003).

Current interventions in place on the hospital, state, national, and global level are guidelines and recommendations based on expert opinion rather than empirical data (ENA, 2011a, Wong et al, 2017). Guidelines are voluntary, they are not rules, they are not written law, they are not mandatory, and they lack discipline and user accountability (ENA, 2011a). Currently there are numerous nursing and occupational organizations that recommend workplace violence prevention plans but there is limited legislative procedures that supports these organizations. Nursing and other healthcare professional organizations and unions are advocating for federal standards and regulations that *require* healthcare institutions to practice effective violence prevention and response (ENA, 2011a). While advocacy for healthcare safety is very active and for good reason, there is still a lack of federal discipline which leads to organizations *self-selecting* which of the interventions it wants to implement (ENA, 2011a).

Behavioral recommendations are that of knowledge, skill, and professional behavior. TJC recommends that RN's should have the knowledge and be informed about incidence and prevalence of WPV within their institution. This includes being knowledgeable about current ethical and legal implications for WPV. Healthcare workers should also have access and be aware of current unit and hospital policies for WPV including updates as they are made available (TJC Sentinel Event Alert, 2018)

Staff skill includes education and training that is recommended by TJC in order to promote staff preparedness in handling, diffusing, conflict resolution, reporting, and

coping with a violent event (TJC, 2012). TJC recommends that all staff be trained in how to respond to a violent situation in a safe, and constructive manner including training on diffusion of potentially, not yet violent situations. Self-defense and personal safety training are also recommended to allow staff to be prepared to defend one's self if de-escalation has failed and a violent situation is imminent. Staff should be aware of a hospital emergency response plan such as escape routes, panic buttons, safe rooms, and notification of the proper management and authority figure. Lastly, staff should be trained on how to effectively and efficiently report a violent incident or threat with whichever reporting system a hospital adopts (TJC, 2012).

Administrative policy recommendations from TJC help hospital staff feel supported when handling or affected by workplace violence (TJC, 2012). A '*zero tolerance*' to workplace violence policy is recommended for both employees and patients alike through not just verbal but written signage. Hospital organizations as a whole are recommended to have a '*workplace violence prevention program'* in place in preparation for encounters with potentially violent situations. TJC recognizes that hospital administration is responsible for support and implementation of a WPV prevention that ensures managers, supervisors, and employees understand their own personal responsibilities for WPV prevention. Management is held accountable for instructing and supporting hospital employees in reporting suspicious or threatening activity that could lead to violent behavior. TJC has additional recommendations for workplace design, hazards within the workplace, security measures, safety procedures, staffing, and work routine/assignments. These recommendations are in part adopted from recommendations of the OSHA and therefor will not be duplicated in this literature review.

Healthcare Staff Lived Experience of WPV

In 2016, Wong et al. (2017) conducted a research study to describe the lived experience of staff members caring for agitated patients in the ED to provide perspective of ED patient violence data that would support the development of a more comprehensive theoretical framework in caring for agitated patients that would guide the refinement of WPV interventions. This qualitative exploratory study used a phenomenological design to explore the psychological, emotional, and systems/process factors for staff who experienced the 'phenomena' of caring for agitated patients.

The study was approved by the New York University School of Medicine's Institutional Review Board. The research team comprised of two emergency medicine physicians and two APRN's in care areas other than emergency medicine to balance professional perspectives to avoid unwanted biases when interpreting data. The study was conducted at a 1,200 bed, urban, tertiary care public hospital in New York City. The hospital under study has an annual ED census of 120,000 patient. Participants of the study were drawn from a collection of staff members working in the ED with direct contact with agitated patients and was made up of ED nurses, ED technicians, physicians, and hospital police officers. Researchers developed a semi-structured interview guide through iterative rounds of mock focus groups with an interprofessional team of the ED administration and educators to pilot and make revisions to the interview process before data collection. Interview questions involved open ended questions with suggested probes relating to the current management of these patients, care provision in the context of safety, and lived experiences of staff members when caring for this population. Convenience sample was utilized in the interview process and interviews were conducted

during optimal times for data collection. Theoretical data saturation was achieved when data collection did not result in new themes during the interview process which was evident after 31 participants were interviewed. Two different forms of interviews were conducted and included either face-to-face or focus group interviews, both lasting from 1 to 1.5 hours a piece. Standardization was ensured between the two interview formats and were cross-checked to ensure consistency of data collection. Interviews were all audio recorded and subsequently transcribed professionally.

The 31 participants in this study consisted of ten hospital police officers, ten nurses, six ED technicians, and six ED residents. Three themes were identified; ED healthcare workers are expected to provide high-quality care to marginalized patient population that concurrently perpetrate harm, stressing the importance of a 'team-based' approach to managing an agitated patient, and environmental factors that influence the care management of the agitated patient Patients who are agitated arrive to the ED, often times being disruptive and uncooperative which makes provision of medical treatment by doctors and nurses very difficult. Additionally, patients under the influence of a controlled substance can be unresponsive or difficult to communicate with, leading to missed life-threatening injuries. These particularly sensitive situations require RNs and physicians to be vigilant and use caution during assessment and treatment despite the patients agitated, disruptive, and potentially harmful behavior. The 'team based' approach is often met with a hierarchal barrier of communication. Alternatively, CNA's and ED technicians often communicate with the RNs who then relay the information to the physician resident/attending. Hierarchal structures and power dynamics among the interdisciplinary team can significantly impede worker and patient safety during a

behavioral emergency care (Wong et al., 2017). Environmental factors often impede care and decrease safety include the chaotic nature of the ED, lack of privacy, long wait times, unbalanced EMS distribution of the agitated patient to surrounding organizations, and pre-hospital staff that may worsen agitated behavior (Wong et al., 2017).

The findings of this study suggest ED workflow interventions are necessary in order to diffuse the agitated patient not just by nursing staff but include the entire hospital system. The patient care paradox has been identified as a significant factor that affects safety. Suggestions include implementing protocols to support comprehensive behavioral healthcare delivery and utilization of a patient care advocate for behavioral health patients, as well as providing targeted support for staff members who encounter the situation. The team factor negatively affecting safety is the silo-based hierarchal means of communication. This study suggests taking a team based interprofessional approach to communication to promote fluidity in patient care. Additional suggestions include an interprofessional workstation to incorporate various team members and interprofessional competency training to promote a team-based effort when providing care to behavioral health patients. Environmental factors affecting safety include overcrowding and exposure. Due to high ED patient volumes, lack of privacy antagonizes an already agitated patient which increases the risk for violent outbreaks towards staff. Recommendations to mitigate this problem is to create more space to absorb increasing patient volume and staffing the unit appropriately to ensure safe nurse to patient ratios. The healthcare system factor affecting safety includes preferential triage versus doing what's best for the patient. Hospitals inadvertently receive unusually high volumes of behavioral health emergencies due to pre-arrival factors such as choice of hospital

transport destination by emergency medical service (EMS) personnel. Suggestions to mitigate this problem include evaluating pre-hospital decision making regarding patient flow and resources, EMS personnel review regarding how to care for the agitated patient and supporting a center of excellence approach vs preferential triage (Wong et al, 2017).

Nurses Perspective on Workplace Violence

From 2009-2011, The Emergency Nurses Association conducted its own survey to establish and recognize the prevalence of WPV in emergency departments across the US. The study investigated ED nurse's perspective on what constitutes as violence, their perceptions of safety and feelings while taking care of violent patients and visitors, contributing factors to escalating WPV, the use and perception and effectiveness of WPV interventions, and reporting of violent incidences. ENA Members from numerous ED's participated and the study sample contained 7,169 completed questionnaires over eight rounds of survey distribution and represented ED nurses from every state. The study tool included 69 questions that contained using a Likert scale rating system, as well a few fill-in-the-blank style questions. Fifty-five (n=3568) of ED nurses reported some form of physical and/or verbal violence within the last seven days of completing the survey. On all accounts of physical (65.6%) and or verbal violence (86.1%), a majority of nurses reported not filing the incident with their hospitals reporting system. Of the nurses who were recipients of physical violence, 46.7% of participants indicated that no action was taken against the persecutor and even less (20.4%) were given a warning. When participants were asked if their emergency department reached out to them for recommendations following incidences, 71.8% reported that there was no response from hospital administration is response to the act of violence they had received. Less than

10% received formal debriefing of any kind and 10.7% of participants indicated that they were to blame for the incidence of physical violence.

Results from questions regarding WPV interventions indicated approximately 70% of respondents had security staff presence at all times and approximately 40% of participants indicated that security was based outside the ED. Mandatory WPV prevention and diffusion training was reported by 55% of nurse responses. Other seemingly important interventions in preventing the occurrence of WPV such as panic buttons, security alert systems, signage, visitor badges, limitations on number of visitors, use of restraints if needed, personal belongings search had a significantly low presence in emergency departments according to survey results from the ENA study. Higher commitment to violence mitigation from hospital administration and ED management and the presence of reporting policies were associated with lower odds of physical violence. Results indicated that 18.3% of the time, violent occurrences take place in hospitals without reporting tools when compared to occurrences just 9% of the time in hospitals with reporting tools and zero tolerance hospital policies in place. Additionally, nurses who identified administrative staff and management as committed to workplace violence control were less likely to experience workplace violence (ENA, 2011a).

As a result of their study, the ENA developed a toolkit for ED managers and hospital administration to outline the necessary components to reducing workplace violence in healthcare. The '*Prevent, Respond, Report'* approach to mitigating workplace violence is outlined in the toolkit. The ENA state that a good WPV prevention program constitutes a combination of environmental safety factors, patient and family-focused safety measures and policy, and staff focused safety measures to include education,

protective behavior training and high-risk identification. Response outcomes to rising prevalence of violence requires preparedness of staff to be adequately trained with the tools to contain a potentially violent situation. A response to violent situations with proper containment procedures minimizes the risk to patient and nurse, as well as, an outward signal supporting patient's rights despite their acts of WPV. Lastly, the authors recommend responding to violent behaviors with well-established roles among the interdisciplinary team to reduce risk of harm. The ENA recognizes that reporting is one of the more important aspects of an ongoing quality improvement initiative in the area of emergency department workplace violence (ENA, 2011b). As nurses, there is a well-known phrase '*if you didn't document it, it didn't happen*', the same phrase can be held true to reporting violent incidences. Hospital administrative staff and management have an easier time implementing and supporting staff if the full magnitude of the problem is understood (ENA, 2011b). Reporting also provides legal documentation for further use as evidence should charges be pressed on the persecutor.

In closing, according to WPV experts, healthcare organizations are recommended to adopt a team-based approach involving employees, employers, law enforcement, prosecutors, and the community as a whole in efforts to advocate for a most efficient WPV prevention program. ED nurses serve an important role in advocating for the future of WPV prevention policies and push for a safer work environment. Hospital employee training and education, environmental safety, and security measures all play an integral part in providing security, prevention, and reduction of WPV. Further investigation of the gaps that exists in understanding the barriers to use of WPV interventions among ED

nurses will assist in defining the ongoing efforts to improve the policy, education and training for WPV mitigation.

Theoretical Framework

Based on current literature and health care statistics within the constructs of nursing, emergency department nurses are among the professional workforce that have the highest rates of WPV. Despite national and state recommendations concerning WPV interventions, there is still an alarming rate of WPV among ED nurses (ENA, 2011a). The knowledge, skill, and attitude toward WPV interventions among emergency department nurses will be assessed in consideration of the Theory of Planned Behavior (TPB).

The Theory of Planned Behavior (Figure 1) was developed in 1985 by Icek Ajzen and is a product of elaboration and improvement to the Theory of Reasoned Action. The Theory of Reasoned Action was developed in 1980 by Ajzen together with Martin Fishbein. The premise of this theory is the exploration of the relationship between a person's behavioral, normative, and control beliefs with intention and behavior. The theory has been utilized in many settings but for the purpose of this major project, the theory will prove useful in describing health behaviors and intention by the use of health services utilization. Health services utilization for the purpose of this major project will be defined as the various WPV interventions that are in place at a given facility.

The TPB states that behavior achievement, in this case, the utilization of WPV interventions depends on both motivation and ability. The theory is comprised of constructs that help identify and represent a person's control over a behavior. The constructs of this theory help explain how a person's beliefs about WPV interventions could have an impact on healthcare organizations intentions to which in turn leads to a behavior.

The constructs of beliefs and actuality will now be explored to support the utilization of this theory for its intended purpose. Behavioral beliefs link a person's behavior of interest with expected outcomes and experiences. It is identified as the probability that a behavior will produce a given outcome. With respect to this project, the goal of the behavior that will produce an outcome represents ED nurses utilizing the WPV interventions in order to reduce WPV. These beliefs in combination with a person's value to the expected outcome determine the attitude towards a behavior. Attitude toward a behavior is the perception that performing a behavior will be either positively or negatively valued.

Normative beliefs refer to the perceived behavioral expectations of the individual or groups and the population being studied. Normative beliefs are correlated with a person's motivation to comply with the behavioral expectations; together a person's beliefs and motivational factors make up a subjective norm. A subjective norm is described as the perceived social pressure to engage or not engage in the expected behavior. For the purpose of this study the normative belief will be identified as the expectation that ED nurses will utilize the WPV interventions. In determining motivational factors of the studied ED nurses, the subjective norm will be measured in order to determine intention and later the behavior that follows.

Control beliefs refer to the perceived presence of factors that either permit or impede the performance of a behavior such as time, ease of utilization, support from organization and managerial staff, etc. It is with the individuals perceived power over these factors that results in a person's perceived behavioral control. The perceived power

over each control factor that either permits or impedes the performance of a behavior is directly related to a person's subjective probability that the control factor is present.

Following the construct of control beliefs, comes the concept of perceived behavioral control and actual behavioral control; both of which influence each other. Perceived control is the individual's perception of their ability to perform a given behavior. In this case, an ED nurse's perception of their ability to utilize the WPV interventions. It is determined by the accessibility a person has to their control beliefs. It states that the strength of each control belief is weighted by the perceived power of the control factor. For example, how much time within an ED nurses shift would they have to dedicate to reporting WPV. Time it takes to report a WPV event is the control belief, and the perceived power is how much influence they have over the amount of time it takes to report a WPV event. Actual behavioral control refers to the extent to which a person has the skills and resources to perform the behavior in question.

The constructs that have been outlined in previous paragraphs are all directly related to behavioral intention and eventual performance of a behavior. Behavioral intention is a measure of a person's readiness to perform a given behavior and is thought to come just before the actual performance of a behavior. Intention, with regard to this theory, is based on a person's attitude toward the behavior and the subjective norm; both of which are measured in relation to the behavior, population of interest and the populations perceived behavioral control. To review aspects of intention, attitude refers to the degree to which a person or population has a favorable or unfavorable evaluation towards the behavior at interest. For the purpose of this project, the attitude that will be assessed is the ED nurses' attitude towards WPV interventions. The subjective norm of

this project is identified as the ED nurse's perception of social and organizational pressure from colleagues and managerial staff to utilize WPV interventions and their perceived ability to actually carry out the interventions in place to reduce WPV.

Using this theoretical framework, provides an opportunity to explore the knowledge, skills, and attitudes towards WPV and the utilization of WPV interventions among ED nurses. By identifying where nurses, departments, or organizations as a whole fall short with WPV interventions as perceived by ED nurses, there is an opportunity understand the perspective of WPV inventions among ED nurses.

Methods

Purpose/ Clinical Question

The purpose of this major project was to assess the knowledge, skills, and attitudes towards workplace violence interventions among emergency department nurses. The questions that were investigated may indicate reasons ED nurses do not utilize WPV interventions at their designated organization, what current organizational interventions are in place to mitigate workplace violence events, and ED nurse perceptions of WPV and WPV interventions. ED nurse responses may assist in determining if there is a lack of knowledge, lack of skill, or negative attitudes towards WPV organizational structures and WPV interventions currently in place.

Design

The research design was a quantitative descriptive research design utilizing a WPV survey of ED nurses who maintain active membership in a statewide Emergency Nurses Association.

Site

The site for research was the Rhode Island State Council of the Emergency Nurses Association. With permission from the Rhode Island ENA State Council, surveys were distributed to RI ENA members on their local email list who are registered nurses in the state of RI. ENA members are employees at acute care hospitals throughout the state. Currently there are 167 registered members of the Rhode Island ENA State Council.

Sample

Convenience sampling was utilized to conduct the survey for this major project. All 167 members of the Rhode Island ENA state council were eligible to participate in the survey. Inclusion criteria was identified as registered nurses who hold a RI state RN

license, currently practicing in an emergency department in the state of Rhode Island and hold a current membership to the Emergency Nurses Association. Registered nurses that were included could have been staff nurses and/or management within the emergency department and could have worked day/evening/night shift; per diem, part-time, full-time. Exclusion criteria was identified as members who were formal orientation to the ED, and RN's who do not hold a current RI nursing license. Registered nurses that practice in more than one state were included, as long as one of the states they hold licensure is Rhode Island.

Procedures

Permission to perform this study was obtained from the Rhode Island College (RIC) Institutional Review Board (IRB) prior to the conduction of the survey. According to the ENA code of conduct, researchers may request to have their study sent out via email to local ENA members with the permission of a board members from the local chapter. The background, purpose, consent form, and survey tool for this major project was submitted to the RI state council and reviewed among board members at their quarterly meeting. A letter of approval to conduct this survey was obtained by the president of the Rhode Island ENA State Council in January 2020 (Appendix A). The survey was distributed via email through the RIENA to its members with a description of the study (Appendix B) and a consent for participation form (Appendix C). Embedded in the consent form was a link to the online Qualtrix survey (Appendix D) which allowed members to participate in the study if they chose to.

Participants had the researcher's commitment to confidentiality and anonymity while taking the survey, as no questions revealed participant's identity. Additionally,

contact information of the researcher was included by providing email and phone number. Included in the consent form, participants were made aware that this was an anonymous, confidential, and voluntary survey and could 'opt-out' at any time during the time they are taking the survey. The consent form also made participants aware of the intended use of survey results and how results would be secured for protection of confidentiality.

Measurement

Demographic data was collected including years of experience, gender, and scheduled shift worked. Responses to each of these questions were in a single word, multiple choice 'yes', 'no', and 'unsure' answer format. The tool used to measure outcomes was an amended version of the ENA workplace violence survey (2011a), composed of 31 multiple choice questions. Modifications were made in accordance to the relevant nature of each question. The original survey tool was validated by the ENA prior to the conduction of their study in 2011, and available to the public on the ENA website. Subsequent modifications included researcher developed questions added to the amended version of the ENA survey tool. The amended version of this tool was piloted by several emergency room registered nurses that do not belong to the RIENA, to establish reliability of the survey questions, most importantly to the researcher developed questions that were added to the survey. Following the pilot survey, the survey was submitted to RIENA for review, feedback and approval. Following RIC IRB, and RI ENA approval, the survey was conducted in the spring of 2020 and had a two-week window for a one-time completion and submission.

Completed surveys were analyzed using quantitative descriptive statistics. The questions on the survey were categorized into describing either knowledge, skill, or attitude (behavioral). Statistical analysis of responses were calculated for each individual question within the three categories. Results from statistically significant questions are presented in graph form along with description of the results and their relevance to the authors purpose.

The survey results were presented in the summer of 2020 at Rhode Island College as a virtual poster presentation. The poster will also be presented to the clinical advancement committee at TMH in the fall of 2020 in the researchers attempt at achieving the clinical scholar designation.

Results

Of the current 167 RI ENA members emailed, 6% (N=10) of members participated in this survey during the timeframe the survey was open. Table 1 displays participants years of reported ED experience.

Table 1

Q3- How many years of experience do you have in the emergency department?

#	Answer	%	Count
1	0-1 year	10.00%	1
2	2-5 years	30.00%	3
3	6-10 years	20.00%	2
4	10+ years	40.00%	4
	Total	100%	10

Nurses with 10+ years of experience compromised the greatest number of responses to this question, however results from this question had responses from all ranges in years of experience. The significance of this finding will be discussed following the review of specific questions addressed from all three categories of knowledge, skill, and attitude.

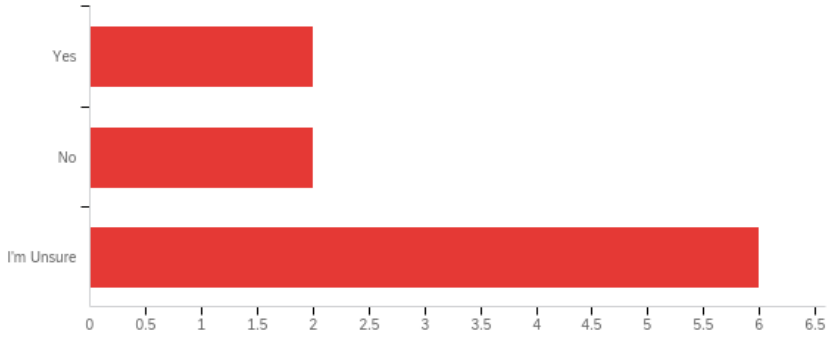
Knowledge of WPV

Knowledge is recognized as facts, information, and skill acquired by a person through experience or education- a theoretical or practical understanding of a subject. Of the questions aimed at determining knowledge, 100% of respondents felt knowledgeable in locating their organizations WPV policies and procedures. Ninety percent of participants reported they could identify administrative personnel that are responsible for the review of a WPV occurrence. Additionally, 80% of participants identified that there was a *zero-tolerance policy* recognized in their organizations policies regarding WPV,

and 80% of participants reported being able to identify where their organizations WPV reporting tool was located. While this data is reassuring, significant data that could represent an opportunity for change was found amongst knowledge-based questions regarding the follow-up procedure following a WPV occurrence. Question 7 (Table 2) asks if the participant is knowledgeable of their organization's procedure following a WPV occurrence, 80% of nurses responded 'no', or 'unsure'.

Table 2

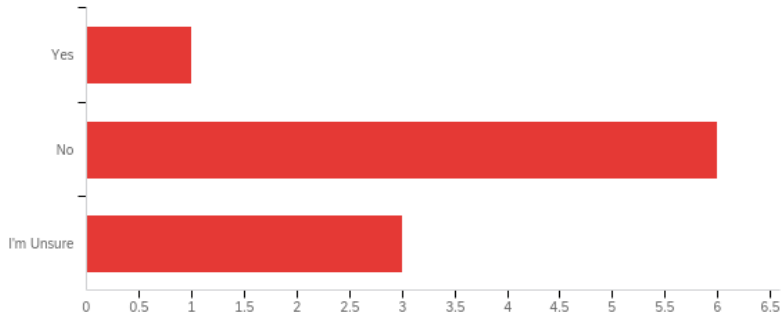
Q5 - Do you know your hospitals procedure following a violent occurrence at the workplace?



Question 14 (Table 3) asks if the participant is knowledgeable in describing the process of review and deposition of a WPV occurrence report that was completed, 90% of nurses responded 'no', or 'unsure'.

Table 3

Q14 - Could you, if you were asked, describe the process of review and disposition of an occurrence report you complete?



WPV Intervention Skills

Skill is recognized as the ability to do something well. Of the nine questions in the skills category of the survey, nurses had a greater than 80% 'yes' responses to all 9 questions. Questions in this category relate to defining WPV, how to look up policies regarding WPV, training and education about WPV, and use of WPV prevention strategies to de-escalate or alert security of a violent/potentially violent occurrence.

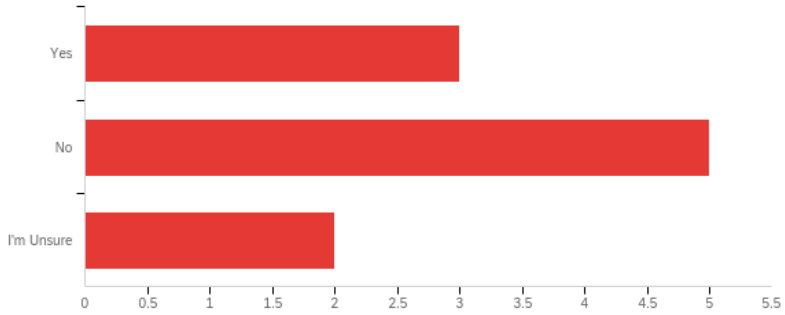
Attitudes regarding WPV and WPV Interventions

Attitude is recognized as a settled way of thinking or feeling about something-typically one that is reflected in behavior. Of the eight questions in the attitude (belief) category of the survey, six of these questions had greater than 60% positive beliefs regarding WPV. Questions in this category aimed at determining how ED nurse felt about WPV and any support, education, and training they had received regarding WPV. Seventy percent of respondents felt that they had adequate support from security, administrative staff and managerial staff when responding to WPV. Seventy percent of nurses also felt that the training and education they received was adequate in providing nurses with the tools to prevent and mitigate WPV. Question 29 (Table 4) asks

participants if the WPV reporting tool is user friendly, 70% of nurses responded either 'no', or 'unsure'.

Table 4

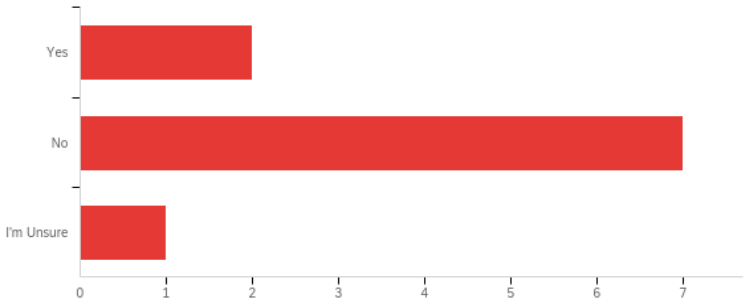
Q29 - Do you feel that the workplace violence reporting tool at your hospital is easy to use, and user friendly?



Question 30 (Table 5) asks the participant if they feel like follow-up responses after filing a WPV report were helpful, 80% of nurse responses reported 'no', or 'unsure'.

Table 5

Q30 - Do you feel that follow up responses after reporting workplace violence occurrences are helpful? (debriefing, follow up from risk management, employee health, unit managers)



In general, the data identified that greater than 60% of respondents responded positively to a majority of the questions presented in the knowledge and skills category of the survey suggesting that nurses felt adequately trained and knowledgeable regarding

WPV. Exceptions within these categories have been discussed in the above tables. The questions provided in the beliefs (attitude) category seemingly have the greatest degree for areas of improvement for future ED nursing practice as two of the questions had significantly negative (beliefs) responses to the questions provided as it was demonstrated in the tables above. This data and opportunities for improving future ED nursing practice will also be discussed in the summary and conclusions.

Summary and Conclusions

Phillips (2016) proposes that the solution to mitigating WPV in the healthcare setting is multifactorial and requires the attention of more than just the health care organization. Policy and law makers, law enforcement, the individual worker, and healthcare organizations need to come together in a collaborative approach, remain consistent, and stay committed to finding a more effective solution to promoting a safer work environment for HCP's (Phillips, 2016).

This survey was based on the findings from the ENA Workplace Violence Surveillance Study (2011a) which sought, in part, to investigate the ED nurse perspective on what constitutes as violence, perceptions of safety, feelings while taking care of violent patients, contributing factors to escalating WPV, the use and perceptions of effectiveness of WPV interventions, and reporting of WPV incidences. The ENA study sample contained 7,169 completed questionnaires and represented ED nurses from every state. When participants were asked if their emergency department reached out to them for recommendations following incidences, 71.8% reported that there was no response from hospital administration to acts of violence experienced, and less than 10% received formal debriefing of any kind. According to the ENA (2011a), a response to violent behaviors with well-established roles among the interdisciplinary team is recommended reduce risk of harm.

The purpose of this major project is to assess the knowledge, skills, and attitudes towards workplace violence interventions among emergency department nurses in the State of Rhode Island. The survey results may indicate barriers to reducing WPV,

improve utilization of interventions currently in place and open up dialogue for more transparent communication regarding WPV policy and procedures.

The Theory of Planned Behavior developed in 1985 by Icek Ajzen was chosen to guide this research as the premise of this theory is the exploration of the relationship between a person's behavioral, normative, and control beliefs with intention and behavior. The theory proved useful in describing how knowledge, skill, and beliefs impact a person's behaviors and intent in the use of WPV interventions. As the constructs of this theory describe, beliefs in combination with a person's value to the expected outcome determine the attitude towards a behavior. Attitude toward a behavior is the perception that performing a behavior will be either positively or negatively valued. If ED nurses do not believe that WPV interventions or the policies and procedures regarding WPV are beneficial to themselves and the system as a whole, according to this theory, the expected behaviors of the nurse are less likely to occur. Data from this research suggests that the attitudes negatively valued by ED nurses is directly correlated to the reduced utilization of WPV interventions.

Convenience sampling was utilized to conduct the survey used for this major project. All 167 members of the Rhode Island ENA state council were eligible to participate in the survey. Permission to perform this study was obtained from the Rhode Island College (RIC) Institutional Review Board (IRB) prior to the conduction of the survey. A letter of approval to conduct this survey was obtained by the president of the Rhode Island ENA state council in January 2020. The survey was distributed via email through the RIENA to its members with a description of the study and a consent for participation form. Embedded in the consent form is a link to the online Qualtrix survey

that allowed members to participate in the study if they chose to. Due to the multiple effects of the COVID-19 pandemic on ED nurses, there were many unforeseen obstacles to online submitting, distributing, and completion of surveys. The final survey was conducted in the spring of 2020 and had a two-week window for a one-time completion and submission.

Demographic data was collected including years of experience, age, and scheduled shift worked. Responses to each of these questions were in a single word, multiple choice 'yes', 'no', and 'unsure' answer format. The tool used is an author amended version of the ENA workplace violence survey (2011a) composed of 31 multiple choice questions. Modifications were made in accordance to the relevant nature of each question. Subsequent modifications included researcher developed questions added to the amended version of the ENA survey tool. The amended version of this tool was piloted by several emergency room registered nurses that do not belong to the RIENA, to establish reliability of the survey questions most importantly to the researcher developed questions that were added to the survey. Completed surveys were analyzed using quantitative descriptive statistics. The questions on the survey were categorized into describing either knowledge, skill, or attitude (behavioral). Statistical analysis of responses were calculated for each individual question within the three categories. Results from statistically significant questions are presented in graph form along with description of the results and their relevance to the authors purpose.

Of the reported 167 RI ENA members, only 6% (N=10) of members participated in this survey. Nurses with 10+ years of experience compromised the greatest number of responses to this question, however results from this question had responses from all

ranges in years of experience. This demographic data proves significant when analyzing the data from all three categories of questions provided in the survey. Within the demographic data collected which included years of experience, age, and shift worked there were many common themes that were identified. This is significant when considering implementing solutions to the barriers of utilizing WPV interventions. Regardless of years of experience, age, and shift worked, the data suggests that the knowledge and attitude barriers remained consistent which further suggests that future interventions do not need to target a particular demographic of ED nurses. The data suggests that all ED nurses would benefit from improvement to WPV intervention policies and procedures which would be intended to facilitate a safer work environment for future nursing practice.

Limitations

Limitations identified within this study are related to convenience sampling, small sample size, and the unforeseen incidence of the global pandemic with COVID-19. The utilization of convenience sample may inaccurately represent the entirety of the ED nurse population due to bias opinions of the subjects included in this study. The small sample size is an additional limitation to this study. The small number of respondents (N=10) limits the validity of the conclusions that were drawn from this study. Data analysis, conclusions, and implications for future nursing practice would have been stronger with a larger sample size. Both convenience sampling and sample size may be attributed to the occurrence of the novel COVID-19 pandemic. ED's and ED nurses across the state of Rhode Island have been under tremendous amounts of unforeseen stressors at work

which possibly could have made participation in this study inconvenient or of less importance due to the state-wide setting of emergency.

Knowledge of Workplace Violence

When analyzing the data from the knowledge-based questions, approximately 80% of respondents reported they were able to locate their organizations WPV policies and procedures, could identify administrative personnel that are responsible for the review of a violent occurrence, could identified that there was a zero-tolerance policy towards WPV, and identify where their organizations WPV reporting tool was located. In contrast to this data, opportunities for improvement arose in other knowledge content. Question 7 asks if the participant is *knowledgeable in their organization's procedure following a violent occurrence*, 80% of nurses responded 'no', or 'unsure'. Additionally, Question 14 asks if the participant is *knowledgeable in describing the process of review and deposition of an occurrence report* that was completed, 90% of nurses responded 'no', or 'unsure'. According to the data collected in the ENA's Emergency Department Violence and Surveillance Study' (2011), higher commitment to violence mitigation from hospital administration and ED management and the presence of reporting policies (especially zero-tolerance policies), were associated with a lower report of physical violence and verbal abuse. The results from this survey indicated that the lack of knowledge in the follow up procedure and deposition process following an event provides an opportunity for improving communication and education regarding WPV policy and procedures from management and hospital-based educators. If commitment to violence mitigation from hospital administration and ED management is associated with lower occurrences of WPV, the policies and procedures should outline the responsibilities

of these personnel and follow up with staff. The hospital personnel responsible for the follow up and deposition following a WPV occurrence should also be held accountable for insuring WPV follow up, including improved closed-loop communication with the ED staff regarding data analytics and subsequent interventions necessary to mitigate future WPV occurrences.

WPV Skills

Analyzing data in the WPV skills category of the survey, ED nurses had a greater than 80% 'yes' responses to all 9 questions. Survey questions were related to defining WPV, how to look up policies regarding WPV, training and education about WPV, and use of WPV prevention strategies to de-escalate or alert security of a violent/potentially violent occurrence. These results indicate that ED nurses know how to define and utilize the WPV intervention strategies however, it appears that barriers identified in WPV knowledge and beliefs may impact nurses from maximizing these skills these skills when required.

WPV Attitudes

The data suggests system-based opportunities are perhaps the most significant areas to address the WPV beliefs (attitude) category of survey questions. The eight questions in this category aimed at determining how nurse respondents felt towards WPV interventions and any support, education, and training they had received regarding WPV; 90% of ED nurse respondents reported positive attitudes (beliefs) towards their hospital WPV initiatives. Seventy percent felt that they had adequate support from security, administrative staff and managerial staff when responding to WPV, nurses also felt that training and education they had received to prepare for WPV was adequate in preparing

nurses with the tools to prevent and mitigate WPV. Questions in this category represent an opportunity for improving WPV interventions and are as follows. Question 29 asks participants if the *WPV reporting tool is user friendly*, 70% of nurses responded either 'no', or 'unsure'. Additionally, Question 30 asks the participant if *they feel like follow-up responses (actions taken against the perpetrator, debriefing, resource provisions, counsel offerings) after filing a WPV report were helpful*, 80% of nurse responses reported 'no', or 'unsure'. The percentage of nurses that felt that follow-up, debriefing of any kind following a violent event was helpful and this closely aligned with the responses of ED nurses found in the original ENA survey. Results from the ENA survey indicated that 46.7% of the perpetrators had no action taken, 20.4% were given a warning. Additionally, 71.8% of respondents indicated that the hospital provided no response concerning the violence they had experienced; only 6% of respondents reported that a formal debriefing occurred following a WPV incident. Although there were no questions about actions taken against the perpetrator of violence in this survey, results from the ENA study indicate that support from hospital administration and ED management are integral in making a difference in reducing WPV. It has been suggested in the literature (Phillips, 2016) that attention from more than just the health care organization and collaboration with community-based partners, such as law enforcement and the judicial system is an essential approach in order to remain consistent, and finding a more effective solutions to promoting a safer work environment for HCP's. The individual worker is responsible for reporting WPV which is more likely to happen if a reporting system is user friendly and there is feedback following completed reports.

Copeland (2017) reports that 26% of nurses who do not report incidences are due to the reporting tool being inconvenient. Reporting also provides a legal representation of what events took place during an occurrence and may be admissible as evidence should criminal charges apply to the occurrence. Administration and ED management should encourage and implement the appropriate follow up actions, lobby for law and policy change regarding WPV against the HCP and involve law enforcement if the involved individual(s) seeks to press legal charges against the perpetrator. Additionally, as mentioned previously, if commitment from hospital administration and management is associated with lower occurrences of WPV, recommendations for future practice should require that they are held accountable to their responsibilities. Accountable responsibilities should be focused on appropriate and timely reporting, follow-up, deposition, and the provision of appropriate resources to staff involved in the occurrence. The results from this survey may guide future policy and procedure change regarding WPV interventions to further prevent, train, and support ED nurses as they continue to encounter these disruptive occurrences.

Recommendations and Implications for Advanced Nursing Practice

The data resulted from this survey demonstrated a few common themes that can be perceived as barriers to utilization of WPV interventions among ED nurses. In Ajzen's theory of planned behavior (1985), he describes normative and controlled beliefs. Control beliefs refer to the perceived presence of factors that either permit or impede the performance of a behavior such as time, ease of utilization, support from organization and ED managerial staff, etc. It is with the individuals perceived power over these factors that results in perceived behavioral control. The perceived power over each control factor that either permits or impedes the performance of a behavior is directly related to a person's subjective probability that the control factor is present. Applying this theory in respect to WPV, it is with the individuals perceived power over these factors (easier to use WPV reporting tools/ adequate follow-up and support following a WPV occurrence) that either permits or impedes the performance of a behavior.

Knowledge based barriers identified were the lack of knowledge in their organization's procedure following a WPV occurrence and the lack of awareness of the review and deposition of an occurrence report that was completed. The lack of knowledge in the follow up procedure and deposition process following an event provides an opportunity for improving education regarding WPV procedures and policy from ED management and hospital educators. If commitment from hospital administration and ED management is associated with lower occurrences of WPV, the policies and procedures should also outline the responsibilities of all members of the healthcare team.

The barriers reported by this sample may be associated with the negative belief findings towards current WPV interventions. Belief (attitude) based barriers identified that the WPV reporting tool *isn't user friendly*, and that participants believed that *follow-up responses after filing a WPV report were not helpful*. Attention from more than just the health care organization and collaboration with community -based partners such as law enforcement and the judicial system is an essential approach in order to find a more effective solution to promoting a safer work environment for HCP's and aid in making the ED nurses voice heard. This will also make law and policy makers aware of the full magnitude of the problem with WPV in the ED. The individual worker is responsible for reporting WPV which is more likely to happen if a reporting system is user friendly as Copeland (2017) described. Recommendations for resolving this issue should target a multi-disciplinary collaborative investigation including ED nursing input to design a WPV specific reporting tool that is easier to navigate which in turn improve rates of WPV reporting.

The role of the Advanced Practice Registered Nurse (APRN) in part, serves as an advocate for evidence-based change and education. In Kotter's '8-step change-model' (Radwan, 2020), the APRN is encouraged to be an activist to effectively promote change within the healthcare system. The APRN has the opportunity to advocate for a multidisciplinary team approach to WPV including policy and procedure changes that promote, develop, and implement a user friendly WPV reporting tool. The APRN can support WPV policy analytics and design requiring that follow-up and a debriefing process is mandatory following all WPV reports and occurrences. The development of these changes as an APRN transformational leader may encourage ED nurses to examine

their beliefs regarding WPV and WPV interventions, and report violent occurrences more frequently to ensure the magnitude of the problem is documented and systematically addressed. APRNs leadership in this crucial at this time, providing support and advocating for the voice of ED nurses who fall victim to workplace violence.

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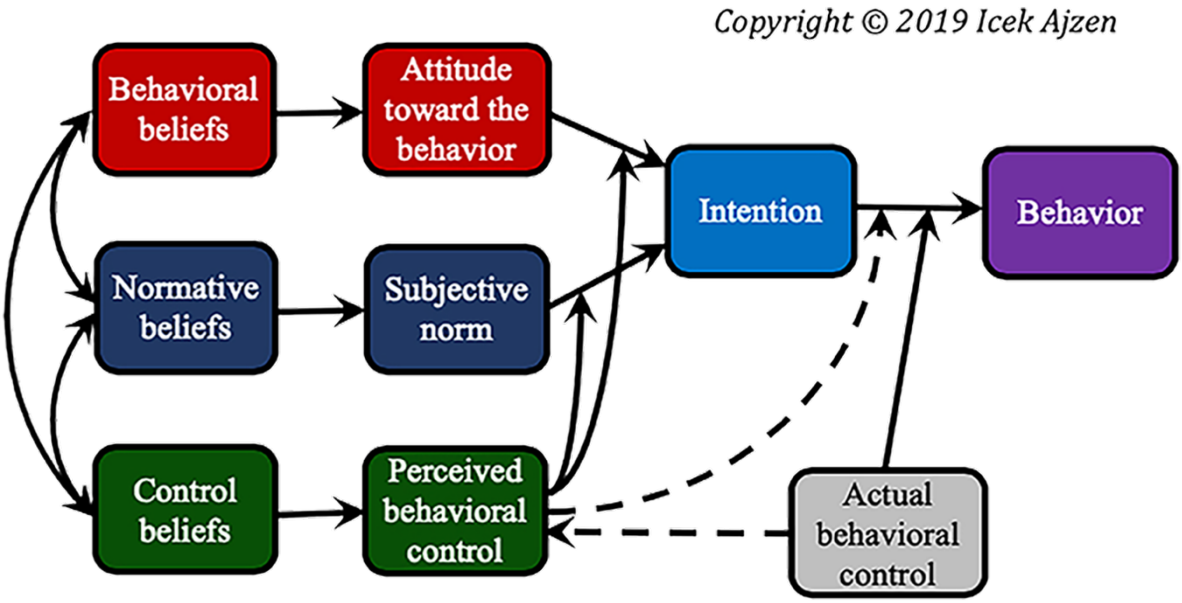
Figure 1. Construct Diagram of the Theory of Planned Behavior (Ajzen, 2019)



Appendix A
ENA Approval Letter

January 5, 2020

Rhode Island
State Council

Dear Jessica,

The Rhode Island State Council of the Emergency Nurses Association would be happy to assist you in your project. We agree to distribute your survey to our membership via electronic mail pending IRB approval of your research. We are happy to promote education and research in the practice of Emergency Nursing.

Thank you for contacting us and we look forward to learning more about your endeavors.

Best regards,

Charlene P. Draleau

Charlene P. Draleau, MSN, RN, CPN, CPEN, NPD-BC, TCRN
Rhode Island State Council President

Appendix B
RIENA Recruitment Letter

Dear Valued ENA Member,

Hello, my name is Jessica Collinson and I am a graduate student at Rhode Island College in the School of Nursing pursuing my MSN degree. Thank you for taking time to read my invitation and considering assisting me in my educational endeavors. The purpose of this research is to assess the knowledge, skills, and attitudes towards workplace violence (WPV) interventions among emergency department nurses. Despite efforts to educate, train, and prevent these episodes from occurring, the trend in WPV toward nurses is rising (ENA, 2011). As a fellow Emergency Nurses Association (ENA) member and emergency department nurse myself, I am hopeful that you will help me in this research study as part of my major project required for graduation. To participate in my research, please click on the attachment in this email to be directed to the consent document. After reading through the consent document, if you wish to participate, click on the link at the bottom of the consent form that will redirect you to the online survey via Qualtrics. The survey will take approximately 15 minutes and is comprised of 30 questions with simple yes/no/unsure replies which are completely anonymous.

Thank you for considering participation in this research study.

Sincerely yours,
Jessica Collinson, BSN, RN, CEN
Rhode Island College School of Nursing
Contact Information:
Email: jcollinson_1618@email.ric.edu
Phone: 401-451-2389

Appendix C
Consent Document

CONSENT DOCUMENT
Rhode Island College

KNOWLEDGE, SKILL, AND ATTITUDE TOWARDS
WORKPLACE VIOLENCE INTERVENTIONS
AMONG EMERGENCY DEPARTMENT NURSES

You are being asked to be in a research study that explores the knowledge, skill, and attitude among emergency department nurses towards current workplace violence interventions. Participation in this study is voluntary and involves completion of an online survey. You are being asked to participate because you are an emergency department registered nurse in the state of Rhode Island who belongs to the Emergency Nurses Association. Please read this form before choosing whether to participate in the study.

Jessica Collinson, BSN, RN, CEN, a graduate student in the School of Nursing at Rhode Island College, is conducting this research in collaboration with the faculty advisor Dr. Margaret Mock, a professor at Rhode Island College.

Why this Study is Being Done (Purpose(s)
The purpose of this research is to assess the knowledge, skills, and attitudes towards workplace violence interventions among emergency department nurses. According to the Emergency Nurses Association (ENA), the trend in workplace violence (WPV) toward ED nurses is rising despite efforts to educate, train, and prevent these episodes from occurring. Identifying the knowledge, skill, and attitudes towards workplace violence interventions among ED nurses may provide organizations with objective data regarding the barriers to current WPV interventions.

What You Will Have to Do (Procedures)
If you choose to be in the study, we will ask you to:

- First, you'll click on the embedded link at the bottom of this consent form which will bring you to the online survey via Qualtrics. The first three questions ask basic demographic data about yourself including age range, years of experience, and what shift you primarily work. This section is brief and will take no more than one minute. Identifying data has intentionally been left out to preserve confidentiality.
- Second, you will continue the survey by reading and answering questions that pertain to knowledge, skills, and attitudes towards workplace violence interventions or the absence of interventions at your institution (you will not be asked to identify your institution). Responses are simple yes, no, or unsure. The entire survey is approximately 30 questions and should take no more than fifteen minutes.

Risks or Discomfort's

The risks of participating in this survey are psychological-emotional. You may find that answering some of these questions may bring up unpleasant past experiences or concerns you have for you or your institution. You may withdraw your participation from the survey at any time if this occurs. If you do experience these unwanted feelings or if you have personal concerns for yourself or the institution, we encourage you to reach out to your department manager, employee health, the employee assistance program at your institution, or risk management department at your institution. The researcher will not be responsible for payments or fees that are required of you as the participant if you chose to seek counseling as an additional alternative.

Benefits of Being in the Study

Being in this study will not benefit you directly, however, your survey responses may provide data that could help our local emergency departments and fellow nurses in reducing and better preparing for workplace violence.

Deciding Whether to Be in the Study

Being in the study is your choice to make. Nobody can force you to be in the study. You can choose not to be in the study, and nobody will hold it against you. You can change your mind and quit the study at any time, and you do not have to give a reason.

How Your Information will be Protected

Because this is a research study, results will be summarized and shared in reports that we publish and presentations that we give. Your name will not be used in any reports as your responses are completely anonymous. We will take several steps to protect the information you give us so that you cannot be identified. No IP addresses will be collected and thus your responses will be de-identified. The information will be kept on a password protected computer to which only the researcher has access to and seen only by myself and the faculty advisor. If there are any problems with this study, the records may be viewed by the Rhode Island College review board responsible for protecting the rights and safety of people who participate in research. The information will be kept for a minimum of three years after the study is over, after which it will be destroyed.

Who to Contact

You can ask any questions you have now. If you have any questions later, you can contact Jessica Collinson at jcollinson_1618@email.ric.edu, or Dr. Margaret Mock at MMock@ric.edu.

If you think you were treated badly in this study, have complaints, or would like to talk to someone other than the researcher about your rights or safety as a research participant, please contact the IRB Chair at IRB@ric.edu.

Statement of Consent

I have read and understand the information above. I am choosing to be in the study *"Assessing the knowledge, skills, and attitudes towards workplace violence interventions among emergency department nurses"*. I can change my mind and quit at any time, and I

don't have to give a reason. I have been given answers to the questions I asked, or I will contact the researcher with any questions that come up later. I am at least 18 years of age.

Click on the link to the survey
https://ric.co1.qualtrics.com/jfe/form/SV_9LA8odjyRl0OKxv

Appendix D

Researcher's Survey

Emergency Nurses Workplace Violence Survey

Amended version of the Emergency Department Assessment Tool (Emergency Department Violence Surveillance Study, 2011)

Demographic Data:

Age:

18-25 years old_____ 26-30 years of age_____ 31-40 years of age _____ 41+ years of age_____

Shift Worked:

Days_____ Evenings_____ Nights_____ Per Diem _____

Years of Emergency Dept Experience:

0-1 year_____ 2-5 years_____ 6-19 years_____ 10 years + _____

Belief based survey questions:

1.) Do you feel like you have adequate support from administrative staff to use WPV interventions at your facility?
Yes_____ No_____ Unsure_____
2.) The established security measures at your facility are helpful in reducing WPV
Yes_____ No_____ Unsure_____
3.) The established WPV interventions at your facility are helpful in reducing WPV?
Yes_____ No_____ Unsure_____
4.) Do you feel that your facilities WPV prevention training program is helpful in assisting staff reduce WPV?
Yes_____ No_____ Unsure_____
5.) Do you feel that the WPV reporting tool in your facility is accessible and easy to use?
Yes_____ No_____ Unsure_____
6.) Do you feel that responses after reporting WPV occurrences are helpful (debriefing, follow up from risk management/employee health)?
Yes_____ No_____ Unsure_____
7.) Do you feel that aggressive/offensive language from a patient and/or visitors is form of violence?
Yes_____ No_____ Unsure_____

Skill based survey questions:

1.) Are you prepared to identify what constitutes as a violent act (verbal & physical)?
Yes_____ No_____ Unsure_____

2.) Do you know how to look up policies and procedures at your facility regarding WPV?
Yes_____ No_____ Unsure_____
3.) Is violence prevention, response and reporting training included in emergency department training?
Yes_____ No_____ Unsure_____
4.) Is violence prevention training mandatory at your facility?
Yes_____ No_____ Unsure_____
5.) If violence prevention training is provided, does training include reporting procedures?
Yes_____ No_____ Unsure_____
6.) If violence prevention training is provided, does training include instruction on de-escalation techniques?
Yes_____ No_____ Unsure_____
7.) Do you use WPV prevention techniques you have learned from your violence prevention training with potentially aggressive/ aggressive patients?
Yes_____ No_____ Unsure_____
8.) Do you know how to notify security in the setting of dealing with an escalating or violent person?
Yes_____ No_____ Unsure_____
9.) Do you use your facilities WPV reporting tool following physical AND/OR verbally abuse?
Yes_____ No_____ Unsure_____

Knowledge based survey questions:

1.) Do you know if your hospital has a zero-tolerance policy to WPV?
Yes_____ No_____ Unsure_____
2.) Do you know your facilities procedure following a violent occurrence at work?
Yes_____ No_____ Unsure_____
3.) Is there a visible, hospital wide initiative to prevent violence in the workplace?
Yes_____ No_____ Unsure_____
4.) Are there institution policies and procedures in place for prevention, responding and reporting violent occurrences?
Yes_____ No_____ Unsure_____
5.) Are you familiar with all your facilities policies and procedures regarding WPV?
Yes_____ No_____ Unsure_____
6.) Do you know where to locate your hospitals WPV policies and procedures?
Yes_____ No_____ Unsure_____
7.) Is there an incident report specific to reporting workplace violence?
Yes_____ No_____ Unsure_____
8.) Do you know how to locate your WPV reporting tool?
Yes_____ No_____ Unsure_____
9.) Is there a policy that describes the process for responding and reporting after an incident has occurred?
Yes_____ No_____ Unsure_____
10.) Is incident reporting mandatory?
Yes_____ No_____ Unsure_____

11.) Do hospital administration (human resources, risk management) participate in the review of violent occurrence report summaries?

Yes_____ No_____ Unsure_____

12.) Could you describe the process of review and disposition of occurrence report you complete?

Yes_____ No_____ Unsure_____